NATIONAL MINORITY QUALITY FORUM

RSV Health Access Action Report

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Letter to the Community

Respiratory syncytial virus (RSV) remains a significant threat to infants, especially those in Black, Hispanic, and American Indian/Alaskan Native communities. This virus is responsible for up to 80,000 yearly hospitalizations and up to 300 yearly deaths in children under five years old.[1] The risks are especially higher for infants, with the most critical cases being infants 0-6 months old.[2]

Prevention is key to combating this disease with recent innovations such as **nirsevimab (Beyfortus),** a preventive antibody that protects against RSV.[3]

The approval of nirsevimab and its inclusion in the Vaccines for Children (VFC) program is a major step forward towards RSV prevention, particularly those in historically underserved communities. VFC, the federally-funded program that offers free vaccines to children in low-income families, has helped expand access to RSV immunization by making it more accessible.[4-5]

However, challenges still threaten the progress and the lives of many infants and children. Administering RSV immunizations before hospital discharge is essential to reaching the goal of ensuring no child is left unprotected. Too many newborns are leaving hospitals without their RSV immunizations, and many are not returning for their two-week pediatric visits. As a result, less than 50% of infants are receiving nirsevimab.[6]

Delayed immunization leads to missed opportunities, particularly for families facing barriers such as lack of transportation, work constraints, and limited healthcare access. By incorporating nirsevimab into routine newborn care at birthing hospitals, more babies can leave protected and unnecessary hospitalizations can be avoided.[7,8]

We urge healthcare providers, birthing hospitals, policymakers, and advocates to act now to establish standard procedures for RSV immunization at birth. Every child should have equal protection from RSV, regardless of their family's socioeconomic background. We must focus on ensuring that nirsevimab is available to all children and implementing it before newborns leave the hospital.

Our collective effort has already driven significant change, with thousands of babies being protected from RSV this respiratory season, yet our work is not done. As we strengthen our commitment to health access and advocate for immediate RSV immunization at birth to protect the most vulnerable population, together, we can build a healthier future for all children.

Background

RSV, or Respiratory Syncytial Virus, causes:

- runny nose,
- congestion,
- coughing,
- decrease in appetite,
- fever,
- wheezing, and
- sneezing.

In infants, RSV may only appear as:

Irritability

Difficulty breathing

Decreased activity[2,3]

RSV season is during the fall and winter, and it's spread through direct and secondary contact with the virus. People with the virus are usually contagious for 3-8 days, unless they have a weakened immune system, in which case they could spread RSV for as long as four weeks.[9]

RSV first emerged as a leading cause for lung infections in infants and children in 1956, and has since become one of the most common childhood illnesses, with 97% of children getting it before their second birthday.[10] A preventive antibody, nirsevimab, that can be given to newborns and immediately provides them with protection against the virus has been developed. Nirsevimab protects the infant from severe RSV immediately upon injection. The immunization offers passive immunity by directly supplying the necessary antibodies, and is critical for babies born in the hospital during peak RSV season.[3,7]

The most recent guidance from the Centers for Disease Control and Prevention (CDC) indicates that the antibody should be introduced from October to March, and it can be administered along with the regular schedule of childhood vaccinations. Nirsevimab is at least 80-90% effective against severe RSV, with an 80% success rate at preventing RSV-related hospitalization. The immunization also has minimal side effects, most of which are mild and resolve themselves within a few days of the injection.[7,11,12]

Landscape of RSV in the US

RSV remains a leading cause of hospitalizations for infants and young children. It is one of the most common and severe respiratory infections that affect these populations. Almost all children contract RSV by the age of two, with most cases affecting the most vulnerable group—newborns and infants between the ages of 0-6 months. The virus threatens infants under six months with life-threatening complications, often requiring long-term admission to the hospital.[1,2,13]

In the U.S., historical RSV surges have followed a seasonal pattern from October through April, with surges typically in December and January. The COVID-19 pandemic changed the patterns of RSV, with earlier surges than usual and unpredictable spikes. In the 2023-2024 season, RSV started following pre-COVID trends, and continued to this season.[14-16] The shifts in transmission patterns have complicated prevention efforts and overwhelmed our healthcare system, however, recent advancements have been made to address these challenges.[14-22]

Data from the National Immunization Survey Adult COVID Module for the 2023-2024 respiratory illness season highlights shifting trends in maternal intent and uptake of nirsevimab for infants under eight months.

Between October 2023 and March 2024, the percentage of mothers who had immunized their infants steadily increased from

13.5% ↗ **41.3%**

reflecting growing adoption over time.

Conversely, those who were unsure or probably would not get nirsevimab fluctuated, peaking at

47.3%
November 2023

↘ before declining to

24.3%
March 2024

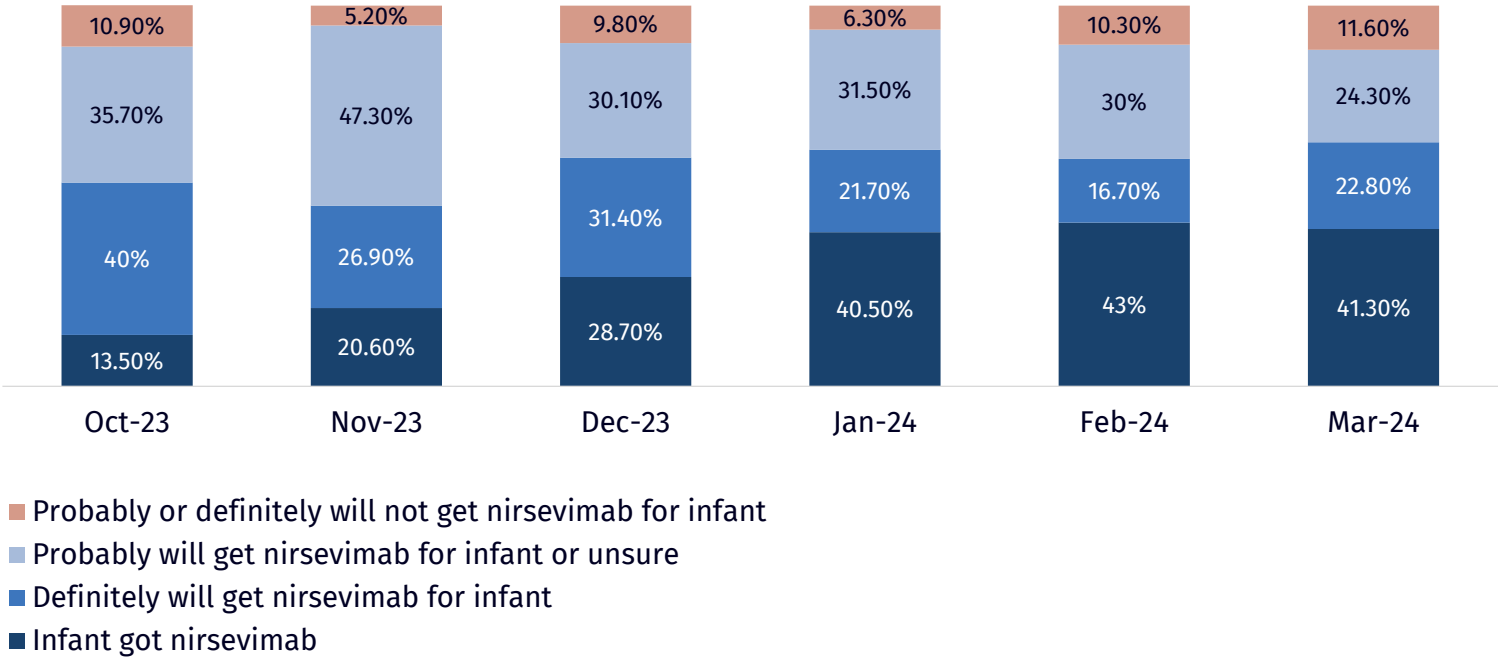
The proportion of mothers who definitely intended to immunize their infants varied, starting at 40.0% in October, dropping to 16.7% in February, and rebounding to 22.8% in March.

Meanwhile, the percentage of mothers who were unlikely to get nirsevimab remained relatively stable, ranging from 5.2% to 11.6%. Although there was originally a decrease of mothers who felt this way, starting with 10.9% in October and dropping to 5.2% in November, the numbers jumped back up to 11.6% by March 2024.

Overall, these trends suggest an increase in immunization while highlighting persistent uncertainty among a significant number of mothers. This further emphasizes the need for continued education and outreach to ensure broader protection against RSV as less than 50% of infants received nirsevimab during last year's season.[23]

Monthly nirsevimab receipt and intent among women ages 18-49 years who have an infant <8 months,

National Immunization Survey-Adult COVID Module (NIS-ACM)



Vaccination rates for pregnant individuals ages 18-49 showed a steady increase from late October 2023 to January 2024, rising from 0.6% up to 17.8%, according to the CDC Vaccine Safety Datalink data. When pregnant individuals receive RSV vaccine, they pass immunity to their infants, eliminating the need for an additional nirsevimab immunization. However, disparities in vaccinations were evident across racial and ethnic groups.

By the end of January 2024,

Black pregnant individuals had the lowest vaccination rate at
10.3%

Hispanic
15.6%

Native American/Alaska Native
17.6%

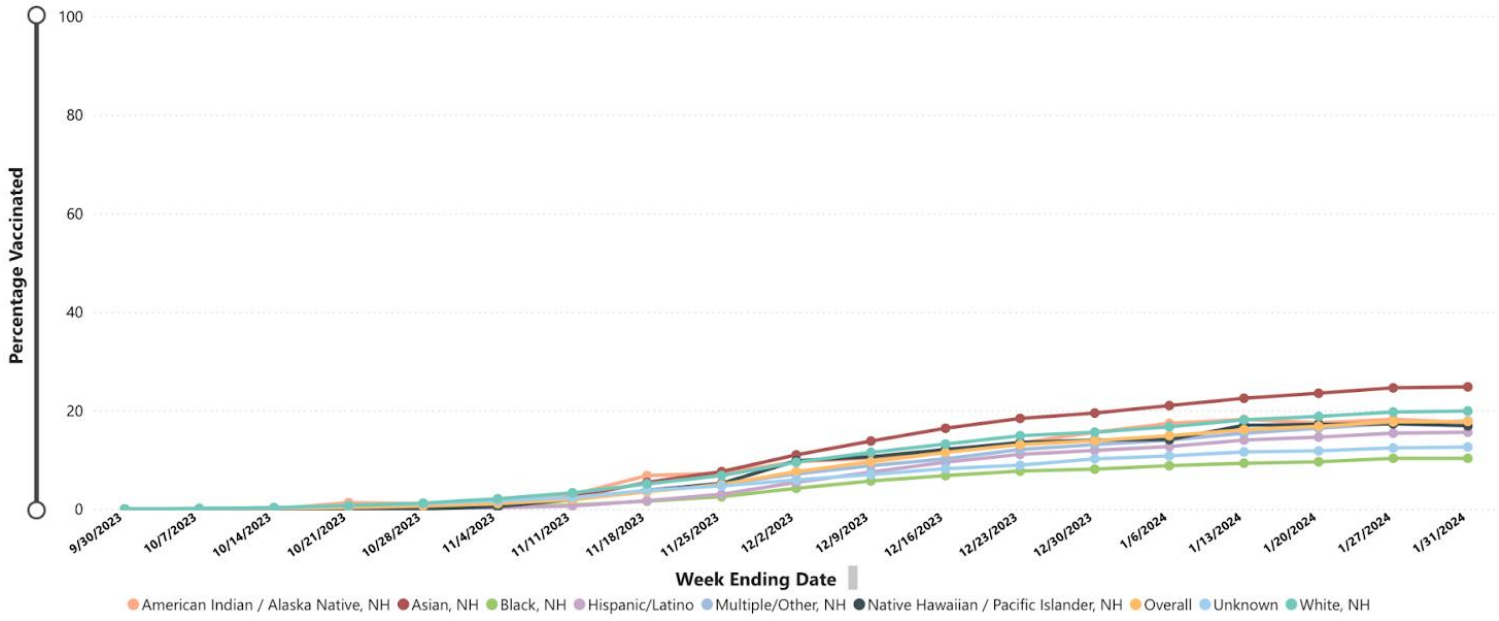
White
19.9%

Asian
24.8%

When combining the rates of pregnant individuals vaccinated and infants receiving nirsevimab, approximately 51% of infants were protected against RSV during the 2023-2024 season. These differences highlight ongoing inequities in access and awareness of RSV immunization, underscoring the need for targeted outreach and support to ensure all pregnant people and their infants receive equal protection against RSV. [23]

Percent of pregnant women ages 18-49 years vaccinated⁺ with RSV vaccine overall and by race and ethnicity

Vaccine Safety Datalink



With the recent addition of nirsevimab being added to the Vaccines for Children (VFC) program, progress has been made to expand the availability. However, there still remains a gap in immunization access and coverage within underserved, low-income communities, specifically children of color. While RSV poses a risk to all infants, its impact disproportionately affects historically underserved communities. Black, Hispanic, and American Indian/Alaskan Native infants experience higher rates of hospitalization due to RSV compared to their white counterparts. These populations are more likely to be enrolled in Medicaid, and research shows that infants with Medicaid are nearly twice as likely to be hospitalized due to RSV and have the majority of RSV-related deaths.[8,24,25]

Socioeconomic disparities, lack of healthcare access, and systemic barriers exacerbate the disparities, preventing many infants from receiving this life-saving immunization and increasing disease burden in these communities.[18,22,25,26] Addressing these inequities of limited access to preventive care is critical to ensuring that all infants, regardless of background, are protected from RSV-related complications.[22,27]

Until recent medical advancements, RSV-prevention efforts were limited to infection control with hand-washing and masking. Prior to the approval of nirsevimab, there was no available immunization for infants, making nirsevimab a major milestone in RSV prevention. This monoclonal antibody immunization was designed to protect infants specifically from severe illness from RSV, providing protection with 80%-90% effectiveness.[3,6,28]

VFC has helped improve accessibility, allowing families in low-income communities to receive this important protection at zero cost. Despite these efforts though, significant challenges still remain with many newborns leaving the hospital unprotected. With the missed opportunities of immunization at birth, other issues arise with lack of follow-up care that continue to put the most vulnerable infants at risk. Addressing these gaps with RSV immunization as a part of the updated newborn care routine is essential to ensuring every child leaves protected.[4,5,23]

Past Advocacy & Achievements

RSV advocacy has been critical to increasing awareness of RSV and building a sustainable action plan against its continued impact on young children and the American public.

In 2018, a survey was conducted with a group of parents and healthcare providers to gauge how aware of RSV parents are;

18%

of parents felt they knew “a lot” about RSV

70%

of healthcare professionals admitted that their patients have little knowledge of RSV

As of this year, the number of parents that expressed at least a moderate amount of knowledge about RSV was 74%, and that number continues to increase as more contributions are made to its treatment and as more educational materials are distributed.[29]

RSV awareness campaigns are critical to the continued development of a knowledgeable parent base and patient-focused care plans. NMQF puts out a yearly report to share information on the state of RSV, and to determine how equitable RSV prevention efforts are. A multitude of other organizations have their own recurring RSV advocacy campaigns, like the American Lung Association, the American Academy of Pediatrics, and the National Coalition for Infant Health among others.[30-33]

As RSV awareness is increasing due to various educational campaigns and national movements, RSV surveillance is increasing as well. The CDC has six systems that are currently monitoring the number of RSV cases and hospitalizations in the United States, the most notable of which are the **National Respiratory and Enteric Virus Surveillance System (NREVSS)** and the **RSV Hospitalization Surveillance Network (RSV-NET).** These networks are updated as often as weekly to ensure that the population has access to timely information about RSV and other respiratory illnesses. These aren't entirely comprehensive databases yet, but they are representative of a national movement away from being blind to the effects of RSV and a shift towards preventive care.[16,34]

The relevance of RSV and the importance of apt care also informed immunization efforts and the development of a protocol that ensured patient access to these immunizations on behalf of those that manufacture the antibody. Sanofi developed the Beyfortus Reservation Program to ensure that healthcare professionals could request the antibody and have their needs met, while also increasing production of the antibody in preparation for RSV peak season.[35] More educational outreach projects that are developed and disseminated results in more patient-oriented care, a more knowledgeable patient base, and less RSV hospitalizations.

It was the scariest time of my life when my daughter contracted RSV. Watching her struggle to breathe —with her distinct cough and high fever—kept me in constant worry. I learned a great deal about RSV during that ordeal and was fortunate enough to be able to care for her full-time. I now wish I had known just how severe RSV can be. Caring for a child battling this virus requires round-the-clock attention, and it saddens me to think of the millions of parents who cannot take time off work to nurse their children back to health. If a vaccine is available to protect your child, please get it.

Chenale Lewis,
Patient Advocate

Impact Without Immunization

Clinical Impact

Without immunization, RSV continues to pose a severe health threat for newborns and infants, with higher risks for those under six months. Infants with RSV can lead to severe illnesses such as bronchiolitis, with mucus build-up and inflammation to the lung's airways, or pneumonia, the inflammation of the lungs. These life-threatening conditions to infants can lead to prolonged hospital stays, intensive care admissions, and mechanical ventilation. In the most severe cases, RSV can cause sepsis or drop oxygen levels dangerously low, potentially resulting in cardiac arrest in infants. It can also result in death.[3,7,8,11,13]

For infants who are even more vulnerable, such as premature infants or those with pre-existing conditions such as congenital heart disease or chronic lung disease, the risks are much higher. Their immune systems are underdeveloped, making them more vulnerable to infection and enduring worse symptoms. RSV infections for these populations lead to severe respiratory distress, often requiring extensive medical intervention.[11,13]

Some studies have even shown that RSV infections during infancy increase the risk of recurrent wheezing, asthma, and long-term respiratory issues later in life. Infants who don't have RSV infections during their first year of life have significantly less chance of developing childhood asthma compared to infants who become infected with RSV in their first year of life. The first year is an extremely important time for the lungs and immune system to develop, making protection against RSV important for the betterment of their development.[18,26, 36-39]

Healthcare providers also face difficulties in managing RSV cases as they increase the admissions to the ICU with longer stays, straining hospitals with no open beds for other critical-care children. This causes further barriers for other infants and children suffering with RSV infections as wait-times for treatment may become longer.[8,18,40-42]

The impact of RSV extends far beyond the clinical setting. Without widespread immunization, RSV will continue to disproportionately affect the most vulnerable infants, contribute to long-term respiratory issues, and exacerbate existing health inequities. Ensuring equitable access to immunization is a critical step in alleviating this burden and protecting the health of all children. Beyond the clinical impact on the infants, the burden on families include emotional distress, financial strain, and disruption to daily life.[43]

Economic Impact

RSV has a significant economic impact yearly, with adult and infant cases resulting in billions of dollars lost yearly. By one estimate, infant RSV cases result in a yearly loss of $1.6 billion, with an estimated 48,499 hospitalizations, 144,599 emergency department visits, and 399,602 outpatient clinic visits from the 3.7 million infants under twelve months in the United States. This number increases by 3-10 times when the child in question has another condition that makes them high-risk. Additionally, because of the high incidence of RSV in infants, and the fact that over 90% of children will have RSV before their second birthday, this economic burden will not reduce on its own.[44]

By one estimate, infant RSV cases result in a yearly loss of

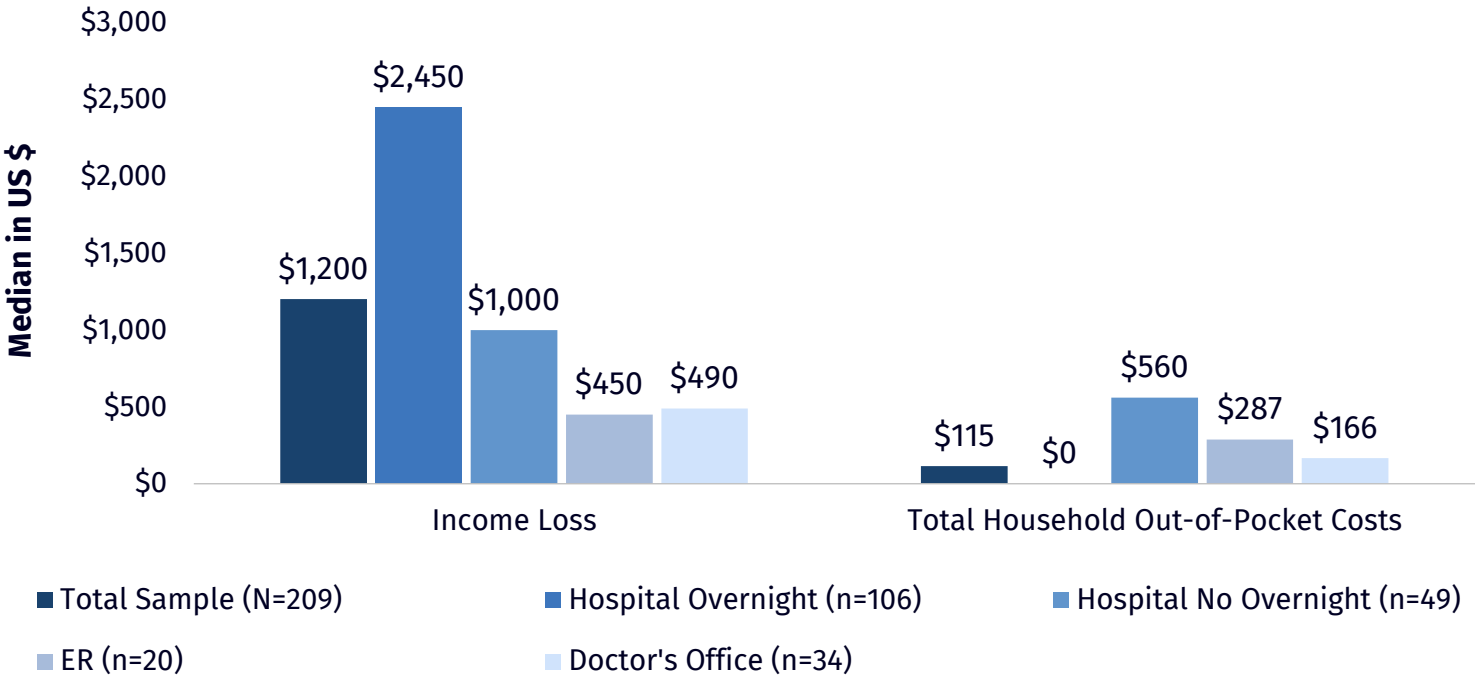
$1.6 B

More than that, adult RSV cases and hospitalizations cost another

$1.2 B

More than that, adult RSV cases and hospitalizations cost another $1.2 billion per year, particularly impacting older Americans and those with pre-existing conditions. In fact, 1 in 20 adults with RSV are hospitalized for their condition within 28 days. These numbers include direct costs, like the cost of hospital visits and outpatient appointments, and indirect costs, like lost wages for parents that have to take off work to care for their children, and more.[45]

Income Loss and Total Household Out-of-Pocket Costs[45]



Note: Income loss was based on responses to the following item: “How much direct loss of income have you experienced since having to care for your child’s RSV or Bronchiolitis? By “direct loss of income,” we mean making less money than you would have, if you did not have to care for the child diagnosed with RSV or Bronchiolitis.”

Current RSV Immunization

Barriers to Immunization

Although most commercial payers cover RSV immunization in the outpatient setting, current reimbursement dynamics pose a challenge for inpatient immunization. The lack of a clear reimbursement pathway for inpatient utilization of RSV immunization presents a significant barrier to widespread adoption of this preventive measure in hospitals.

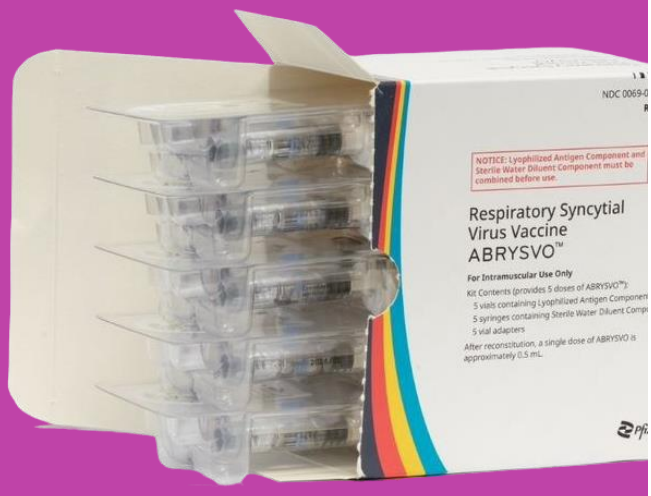
Another barrier to the RSV immunization is the awareness of and the attitude surrounding this disease and its immunization in particular. The main reason that older adults at risk for developing severe RSV that leads to hospitalization didn't receive the RSV immunization was because they weren't aware of its existence or efficacy.[48] Many parents of infants recognize the importance of protection against RSV, but one survey showed that 24% of parents are hesitant to vaccinate against RSV.[49]

Market Research

Understanding how RSV immunization uptake and the public's perception of it is crucial for improving access and ensuring equitable protection for all infants across the country. With the current trends of increased immunization rates, RSV rates have seemed to have decreased for the 2024-2025 season. However, disparities still remain, affecting thousands of infants' lives.[15,16]

Recent data indicates a steady, but slow, increase in RSV immunization rates in infants across the country, with significant disparities based on demographic and geographic factors.

Despite the approval of nirsevimab and **maternal RSV vaccination (Abrysvo),** immunization uptake still remains lower than expected, particularly among Black and Hispanic communities.[8,25,36,50]



Interviews with parents showed significant knowledge gaps about RSV immunization, with only 38% planning to give nirsevimab to their newborn, 25% opting out, and 38% uncertain about whether they will give it to their newborn. Key factors that influence the immunization uptake included trust in pediatricians and the fear of RSV complications. Meanwhile, fear of immunization side effects and misinformation played a role for the other parents, as some viewed nirsevimab as an untested vaccine similar to their views to the COVID-19 vaccinations.[51]

A survey of U.S. pediatric providers reinforced these findings

99%
agreeing that parents need more RSV and nirsevimab education

86%
incorporating RSV discussion into routine care visits,

97%
recognizing immunization as a crucial preventive measure

92%
supported policies ensuring equitable access to RSV immunization.[40]

Disparities in RSV immunization access and uptake persist across socioeconomic and racial groups, highlighting systemic barriers that may limit protection for vulnerable infants. Data show that infants from publicly insured families were less likely to receive nirsevimab compared to those with commercial insurance, indicating financial and access-related obstacles. Additionally, racial disparities were evident, with infants of Black and Hispanic mothers having lower overall RSV protection rates compared to those of white and Asian mothers.[25]

Further challenges included differences in awareness, cultural perceptions, and systemic barriers such as insurance coverage restrictions, reimbursement complexities, and limited outreach to historically under vaccinated communities. Expanding access through initiative like the VFC program, culturally sensitive education, and provider engagement could help bridge these gaps. By addressing these inequities, more infants, especially those from marginalized backgrounds, can benefit from lifesaving RSV immunization.[25]

Current Attitudes

Public attitudes toward RSV immunization are shaped by a combination of awareness, trust in healthcare recommendations, access to information, and perceived risk. While the introduction of nirsevimab and the maternal RSV vaccine represents a major advancement in RSV prevention, hesitancy and barriers remain that impact uptake across different communities.[52]

The uptake of nirsevimab has outpaced that of the maternal RSV vaccine, suggesting shifting attitudes and preferences in RSV immunization strategies. One reason for this trend is the perception of monoclonal antibodies as distinct from traditional vaccines, reducing concerns tied to vaccine hesitancy. **While 77% of pediatricians have offered nirsevimab in their practices, some barriers remain, including parental concerns over long-term safety, financial burden, and insurance reimbursement challenges.** Despite these obstacles, over 95% of pediatricians agree that nirsevimab is both safe and effective, reinforcing its role in RSV prevention.[50,53]

A key driver of immunization uptake has been provider recommendation, with higher maternal and infant immunization rates observed when healthcare professionals actively encouraged RSV protection. Data from the 2024 National Immunization Survey show evolving trends in parental intent for nirsevimab receipt.

August 2024

43.0%
of mothers reported they would definitely get nirsevimab for their infants

September 2024

rising to
52.7%

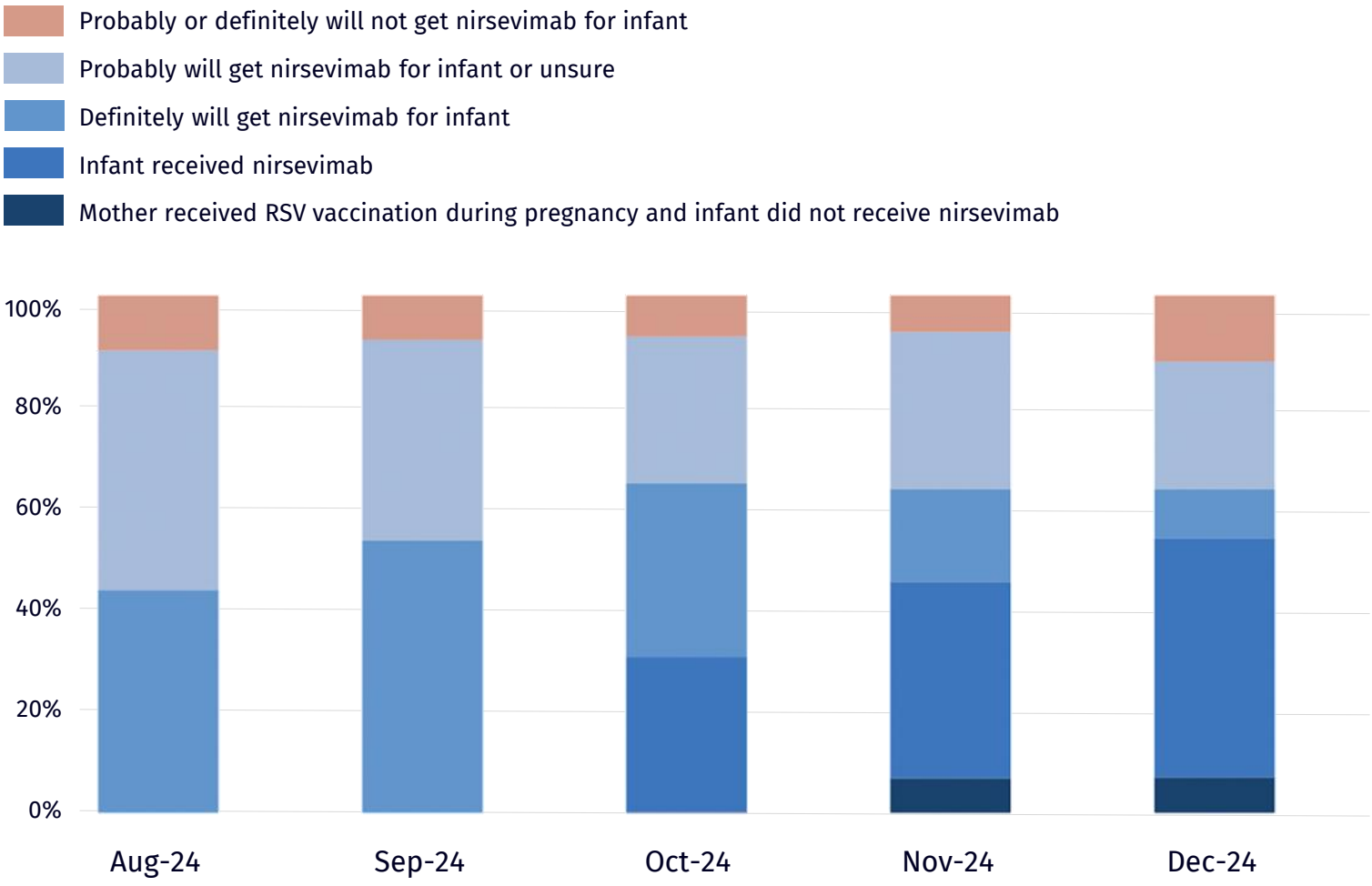
December 2024

46.1%
of infants had received the nirsevimab vaccine.

The proportion of mothers receiving the maternal RSV vaccine remained minimal, peaking at just 6.9% in December 2024.[54]

Infant protection against RSV by maternal RSV vaccination* or receipt of nirsevimab,† and intent for nirsevimab receipt,‡ Reported by females aged 18-49 years who have an infant <8 months during the RSV season (born since April 1, 2024), by month of interview, United States§, ±

Data Source: National Immunization Survey-Adult COVID Module



Females with an infant <8 months

There was also a concerning trend of increasing parental refusal of nirsevimab over time. In August 2024, 10.7% of mothers reported they would probably or definitely not get nirsevimab for their infants. By October, this percentage had dropped slightly to 7.9%, but by December, it had risen sharply to 12.8%. At the same time, the percentage of mothers who were unsure or hesitant about nirsevimab also declined from 46.3% in August to 24.6% in December, suggesting that more parents moved from uncertainty to outright refusal. This shift coincided with a sharp decline in maternal RSV vaccination rates, which peaked at just 6.9% in December. These trends highlight growing parental hesitancy, underscoring the need for targeted education and provider engagement to address concerns and improve RSV protection for infants.[54]

Disparities in RSV protection remain, particularly among younger mothers and Black mothers, who have lower overall RSV immunization rates—largely due to differences in maternal vaccine uptake and access to nirsevimab. Asian infants had the highest protection rates (86.7%), while Black infants had the lowest (70.2%). These findings suggest that increasing awareness and provider engagement, particularly for maternal RSV vaccination, could improve overall RSV protection coverage. Addressing systemic barriers such as financial challenges, insurance restrictions, and provider-patient communication gaps could further enhance immunization efforts and reduce RSV-related hospitalizations in infants.[22]

Black infants had the lowest protection rates

70.2%

The Role of Commercial Payers

The RSV immunization is cost-effective and has shown significant improvements in the conditions of infants impacted by RSV. Studies show that this immunization is most cost effective for children that are as much as ten times more likely to experience severe RSV symptoms and hospitalization, with a cost of about $308,468 for each year of improved health.[36] This immunization also could reduce 107,253 outpatient visits, 38,204 ED visits, and 14,341 hospitalizations each year if just half of eligible US infants receive the immunization. Furthermore, the Advisory Committee on Immunization Practices (ACIP) recommends this immunization for all infants born during or near the RSV peak season, and their recommendation was reliant on this measure being monetarily practical.[36]

The immunization against RSV is a critical tool for saving the lives of the most

Solutions

To protect all infants from the burden of RSV disease, it is essential that nirsevimab be made more accessible to all infants born during the season, ideally administered in the hospital immediately following birth as recommended by the CDC. This is especially important for families from from underserved racial and ethnic communities. The inclusion of nirsevimab in the Vaccines for Children (VFC) program was a major step forward towards RSV prevention, particularly those in historically underserved communities. It is imperative that birthing hospitals prioritize enrollment in the VFC program and identify a path for payment for commercially insured infants. In addition, healthcare providers need to be trained and equipped to offer nirsevimab to newborns in marginalized communities. This will require a concerted effort to ensure that no family is left out due to financial or logistical barriers.

Hospital-based immunizations at birth is a key strategy for ensuring early protection against RSV. For those infants, whose mother's had not received RSV vaccine, administering nirsevimab immediately after birth for infants born during RSV season, particularly in high-risk populations, can help bridge the gap in immunization rates and ensure that all infants receive timely protection.[7] This would require coordination between birthing hospitals, pediatricians, and public health agencies to standardize the practice and ensure widespread implementation.

To support providers, healthcare institutions and professional organizations should implement training programs and resources to help them effectively communicate the benefits of nirsevimab. Ensuring that providers have the tools to address parental concerns and navigate logistical barriers will be essential in increasing the uptake of nirsevimab.[55]

Equally important is the need for an extensive public health campaign to raise awareness about RSV and the availability of nirsevimab and maternal RSV immunization. Educational efforts must be tailored to meet the cultural and linguistic needs of diverse communities, ensuring that parents and caregivers understand both the threat of RSV and the value of immunization.[30-33] Trusted local healthcare providers and community leaders can play a pivotal role in dispelling myths and increasing trust in the vaccine. By leveraging existing community networks, the message of vaccine safety and efficacy can be communicated effectively, ultimately reducing vaccine hesitancy and encouraging higher immunization rates.[56]

The access and quality of health care in underserved areas must also be strengthened to ensure that all families have access to immunization services. This includes providing support to primary care facilities that serve marginalized communities and enabling them to offer nirsevimab as part of their regular vaccination schedules. Mobile vaccination clinics could also be a valuable tool in reaching remote or underserved communities, where fixed healthcare facilities may be limited.[25,57]

Furthermore, there must be a focus on the collection and analysis of data to monitor immunization rates and track the progress of these efforts. It is essential to have detailed data on the uptake of nirsevimab, especially within specific racial and ethnic groups, so that targeted interventions can be developed where the need is greatest. Regular monitoring can help identify any disparities in vaccination rates and ensure that resources are directed to the communities that are most at risk.

Community-based outreach will be critical to the success of these initiatives. Local organizations that serve people of color often have established trust and rapport with their communities, making them ideal partners for distributing information and facilitating access to vaccines. By collaborating with these organizations, public health authorities can ensure that the message about RSV disease and RSV prevention strategies reaches those who need it most. Community leaders, faith-based organizations, and local healthcare professionals can be instrumental in organizing vaccination clinics and providing the education necessary to overcome barriers to immunization.[56,58]

Collaboration between public and private sectors is another key component of this effort. Public-private partnerships could also support innovative approaches such as mobile vaccination units or community health programs aimed at increasing immunization rates in hard-to-reach areas.[57,59]

Finally, policy reform is crucial to addressing the structural inequities that contribute to health disparities. Policymakers must prioritize healthcare reforms that ensure access to vaccination for all populations, particularly those historically disadvantaged. By supporting policies that expand access to vaccines and improve healthcare delivery in underserved communities, lawmakers can make a significant impact on reducing disparities in RSV immunization rates.

Through these combined efforts of enhancing access to the vaccine, increasing awareness, strengthening healthcare infrastructure, and fostering collaboration among public and private sectors, it is possible to ensure that more infants, particularly those from communities of color, receive the protection they need against RSV.

This approach will help eliminate barriers to immunization, ensuring better health outcomes to reduce the burden of RSV on vulnerable populations and ensuring every child leaves protected.

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